If you have questions regarding your response, contact the following:

- Risk Management Specialist at 785-291-3552

FAX NUMBER: 785-291-3419

Checklist

We suggest you us the checklist below as a guide for the actions on your plan of correction.

- Have you provided a response for each deficiency listed?
- Do you have a completion date?
- Is each plan descriptive as to how the correction will be accomplished?
- Have you indicated how you will monitor your actions on the plan of correction?
- Have you indicated who is responsible for ensuring the actions on the Plan of correction are completed.

Your response may be returned for further clarification if the agency feels more information is needed.

Kansas Department of Health and Environment
Bureau of Community Health Systems; Health Facilities Program
1000 SW Jackson, Suite 330, Topeka KS 66612-1368
FAX (785) 291-3419

Statement of Deficiencies and Provider Response

RISK MANAGEMENT

Surveys

Instructions regarding the submission of a provider response.

Revised 01/15

Introduction

Surveyors from the Kansas Department of Health and Environment (KDHE) recently completed a Risk Management (RM) survey of your facility. A list of findings identified by the surveyors is on the attached *Statement of Deficiencies (SOD)* form.

We are requesting you submit a response for each deficiency listed on the form. Your response should be entered on the Provider's Plan of Correction form attached and the form should be submitted back to KDHE within 21 days of receipt of the list of deficiencies.

The Statement of Deficiencies

Surveyors visit your facility, write any deficiencies on the Statement of Deficiencies form, and then provide it to you. Write your response on the form and return it to KDHE. The Statement of Deficiencies should be viewed as providing you with an opportunity to furnish documentation that deficiencies are being addressed.

Submitting Your Response

Providers are encouraged to respond to the *Statement of Deficiencies* electronically as an attachment to an e-mail whenever possible and submit the signature and date page via FAX to 785-291-3419. Review the next three sections regarding descriptive content, completion dates, and continued monitoring. Respond to each plan of correction **on** the form opposite the respective deficiency. If you need additional space, continue on an attached sheet. However, be sure to refer to the deficiency number or State regulation number and identify the attachment (e.g., Attachment to Page 2 of 4). If you include exhibits, identify them (e.g., Exhibit A) and refer to them as such in your plan of correction.

Descriptive Content

Your response should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence. The plan should provide information that ensures the intent of the regulation– as evidenced by the examples cited-- is met.

If a deficiency has already been corrected, we recommend the plan state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

Note: Instruction or in-service of staff alone may not be a sufficient response. This is a good first step toward correction. Additional steps should be taken to ensure the deficiency is corrected and will not recur. If you are in disagreement with the statement of deficiency you may advise as to why you are in disagreement and indicate why your process or decisions were correct for a given situation.

Completion Dates

The response you provide should include a completion date (entered in the far right-hand column). Be sure the date is realistic in the amount of time your facility will need to correct the deficiency.

Direct care issues should be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies requiring letting of bids, remodeling, replacement of equipment, etc., will require more time to accomplish correction but should show reasonable time frames.

Continued Monitoring

We ask that each response indicate the **appropriate** person — by **position**, not name — who will be responsible for monitoring the correction of the deficiency to prevent recurrence.

Signature and Date

The Statement of Deficiencies form is to be signed and dated by the administrator or other authorized official. It is only necessary to sign and date the first page.

Time Frame

We request that your plan of correction be mailed within 21 calendar days from the date of receipt. Please retain a photocopy for your records.

Standard of Care (SOC) Assignments v/s Survey Findings: In the event there is disagreement between the state surveyor findings and your assignment of a SOC, you are not required to amend your SOC. The only time we will ask a facility to seek peer review and possibly amend the SOC should be rare and must be approved by the Director of the Health Facilities Program.

Mailing Address (where needed)

HEALTH FACILITIES PROGRAM
BUREAU OF COMMUNITY HEALTH SYSTEMS
KS DEPT OF HEALTH & ENVIRONMENT
1000 SW JACKSON SUITE 330
TOPEKA KS 66612-1368

Questions?

Please review the cited regulation first. If you need clarification, have questions about the deficiencies or if you disagree with any deficiency, you may contact either person listed in the order below:

Risk Management Specialist	**Topeka**	**785-291-3552**
Director of Health Facilities Program	**Topeka**	**785-296-0131**